Application for Children's Financial Assistance

To begin the financial aid process, just complete this form and return it to a Children's registration desk *or* mail it in a stamped envelope to:
Children's Hospital and Regional Medical Center, Business Services Financial Counseling, M/S S-100, P.O. Box 50020, Seattle, WA 98145-5020

Please note: If your child is already enrolled in Medicaid, Healthy Options or Basic Health Plus, you do not need to fill out this application.

Please list all children or teens in your home receiving care at Children's.

Patient name(s) ______________________________

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Patient medical record number(s), if known ______________________________

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Does your child (or your children) receiving care at Children's currently live in Washington, Alaska, Montana or Idaho? ☐ **Yes** ☐ **No**

When did your child(ren) first start living in Washington, Alaska, Montana or Idaho?

____

Did your child(ren) ever live outside Washington, Alaska, Montana or Idaho? ☐ Yes ☐ No

If yes, where?

____

Are there any other children or teens living in your home for whom you are responsible? ☐ **Yes** ☐ **No**

Names and birth dates of other children under age 21 living in your home. If you are pregnant, please count the unborn child.

Name ____________________ Birth date ____/____/____

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Name ____________________ Birth date ____/____/____

Name ____________________ Birth date ____/____/____

Your name as Responsible Party: ______________________________

____

Social Security number, if known ________–________–________

Birth date (month, day, year) ________/________/________

Mailing address, city, state, ZIP code ______________________________

____

Home phone number (   ) ______________________________

Employer's name and phone number ______________________________

______________________________(   )______________

Do you have a spouse or is the child's other parent living with you?
☐ **Yes** ☐ **No**

Name of spouse or child's other parent living at home ______________________________

____

Social Security number, if known ________–________–________

Birth date (month, day, year) ________/________/________

Employer's name and phone number ______________________________

______________________________(   )______________

Your monthly household income before taxes (monthly gross income, not take-home pay):

Monthly salary (combined) $______________

Child support/alimony $______________

Farm or self-employment income $______________

Military family allotment $______________

Public assistance $______________

Pension or veteran's benefits $______________

Social Security check $______________

Rental income $______________

Unemployment compensation $______________

Grants $______________

Workman's compensation $______________

Investment income $______________

Your total household income: $______________

If you have no listed income, please explain how are you paying for food and housing:

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____

____

Please note:

> *We do not guarantee that you will qualify for Children's financial assistance even if you send in this application or get help from a Children's financial counselor.*

> *Once you send in your application, Children's may check all information in it. We may ask for proof of income (for example, pay stubs or a tax return).*

> *Within 14 days of receiving your application, we will let you know in writing whether you qualify for Children's financial assistance.*

Responsible Party's Consent and Agreement

I confirm that the information in this application is correct and complete and that Children's has my permission to double-check it for accuracy. I understand that if Children's finds any of this information to be intentionally false, I will lose any Children's financial assistance and I will be responsible for all hospital, clinic and doctor charges.

I also give Children's permission to release information on this application to the Community Health Access Program (CHAP), which might be used to search for other financial assistance sources.

______________________________ Date ____/____/____

Responsible Party's Signature